

Continuity of Care

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Introduction

- 35 years ago, the late Prof. Bruce Winick called our attention to "the well known chain of events [involving criminal defendants with mental disabilities] from incompetency determination to hospital to stabilization to return to jail to decompensation to re-determination of incompetency to re-hospitalization several times."
 - Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. Rev. 921, 934 n. 52 (1985).
- Some 20 years ago, I noted how psychiatric hospital commitments of this population "are frequently followed by a 'shuttle process' by which defendants are stabilized, returned to jail to await trial, and returned to the hospital following relapse."
 - Michael L. Perlin, "For the Misdemeanor Outlaw": *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALABAMA L. REV. 193, 204 (2000).

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Introduction, 2

- And four years ago, former President Barack Obama noted the existence of "a relatively small number of highly vulnerable individuals [who] cycle repeatedly not just through local jails, but also hospital emergency rooms, shelters, and other public systems."
 - Barack Obama, *The President's Role in Advancing Criminal Justice Reform*, 130 HARV. L. REV. 811, 848 (2017).

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Introduction, 3

- This multi-dimensional problem has *not* gone away.
- We must take seriously the entire bundle of issues that are raised by this phenomenon – how we treat this population; how we fail to learn from our history of failure; how we ignore options that might potentially ameliorate the underlying situation; how we demand quick fixes, and ignore the “long game”; how we criminalize behavior that disproportionately affects people with mental illness.

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Introduction, 4

- This shuttling or cycling is bad for many reasons, not least of which is the way that it deprives the cohort of individuals at risk from any meaningful continuity of care, and how it exacerbates the problems caused by the unnecessary and counterproductive arrests of persons with mental disabilities for “nuisance” crimes.

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Introduction, 5

- By the phrase “continuity of care,” I adopt the definition offered by Bruce Frederick : “1) continuity of control, 2) continuity in the range of services, 3) continuity in service and program content, 4) continuity of social environment, and 5) continuity of attachment.”

* --Bruce Frederick, *Factors Contributing to Recidivism among Youth with the New York State Division for Youth: Research Report* (1999), as quoted in David M. Altschuler & Troy L. Armstrong, *Juvenile Corrections and Continuity of Care in a Community Context—The Evidence and Promising Directions*, 66 FED. PROBATION 72, 73 (Sept. 2002).

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Introduction, 6

- Continuity of care further requires “1) treatment in facilities that prepare offenders for reentry into the specific communities to which they will return, 2) making the necessary arrangements and linkages with people, groups and agencies in the community that relate to known risk and protective factors, and 3) ensuring the delivery of required services and supervision.”
- Rebecca Spain Broches, *Creating Continuity: Improving The Quality of Mental Health Care Provided to Justice-Involved New Yorkers*, 21 GEO. J. ON POVERTY L. & POLY 91, 100 (2013). (NB: this is the most valuable article to read in this area!)
- Without this continuity, it is far less likely that any therapeutic intervention will have any long-lasting ameliorative effect.

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Introduction, 7

- I believe that our current system fails miserably to meet any of these prescriptive standards.
- The current system – in addition to being utterly counter-productive (and in many ways, destructive) – is also violative of the constitutional right to treatment, and the statutory right to non-discrimination as provided in domestic (the Americans with Disabilities Act) (ADA) and international (the Convention on the Rights of Persons with Disabilities) (CRPD) human rights law.

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Roadmap

- First, I briefly discuss the current state of affairs.
- Then, I will review the valid and reliable research as to why continuity of care is clinically necessary is so often missing, and how the failure to provide this continuity leads to the problems we currently face.

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Roadmap, 2

- I then set out the legal arguments -- constitutional and statutory -- that we believe need to be relied on to remediate the current situation.
- After this, I show how our current system violates every precept of therapeutic jurisprudence, as well as the basic principles of international human rights law, and argue for the enhanced use of mental health courts.

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Continuity of care

- There is no question that the lack of continuity of mental health services severely impairs the ability of community-based mental health providers to have any therapeutic impact on this population.
 - "While incarcerated, many of these people received inadequate treatment and deficient, if any, reentry planning. Once released to the community, many received insufficient support and subsequently were reincarcerated."
 - Henry A. Dlugacz & Luna Droubi, *The Reach and Limitation of the ADA and its Integration Mandate: Implications for the Successful Reentry of Individuals with Mental Disabilities in a Correctional Population*, 35 BEHAV. SCI. & L. 135, 139 (2017).

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Continuity, 2

- We have known for years the prevalence of medical errors arising in cases in which there is such discontinuity of care, and the fact that our incarceration policies have had unintended adverse health consequences.
- The range of negative outcomes includes, but is not limited to, having no permanent residence post-release along with a suicide rate eight times higher than the general population.

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Continuity, 3

- There is positive impact when models of care are in place.
 - Such models improve post-release engagement with mental health services.
- Now widespread agreement that transition planning is essential to facilitating continuity of care for soon-to-be released inmates with mental illness, and that correctional systems can have a “direct effect” on the health of urban populations by linking inmates to urban services after release.
 - Such implementation requires political and constituent support and investment of resources.

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Role of correctional facilities

- Correctional facilities must engage in clinically-oriented reentry programs.
- In addition to access to health care services, as part of a successful re-entry program, ex-prisoners must also have access to meaningful peer mentoring programs, supported employment and supported housing.
- Successful re-entry programs – programs that are collaborative as between the criminal justice system and the behavioral health system must be a “primary focus of correctional mental health care, [and] not an afterthought.”
 - – Henry A. Dlugacz, *Community Re-entry Preparation/Coordination*, in OXFORD TEXTBOOK OF CORRECTIONAL PSYCHIATRY 76, 77 (Robert L. Trestman, Kenneth L. Appelbaum & Jeffrey L. Metzner eds. 2015).

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Correctional facilities, 2

- Required: A critical assessment of the mental health services typically available in a correctional institution, an assessment that must be carried out in light of the “overarching resistance to considering rehabilitation” as a primary goal of corrections.
 - Latter attitude contributes to the “isolation” that care providers in correctional settings often experience, and further “reinforces the disconnection of care and inadequate attention to clinically oriented reentry programs in clinical settings.”
- Henry A. Dlugacz & Eric Roskes, *Clinically Oriented Reentry Planning*, in HANDBOOK ON CORRECTIONAL MENTAL HEALTH 395, 400 (Charles L. Scott ed. 2010).

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Correctional facilities, 3

- Proper assessment of the needs of inmates in this context requires an “interdisciplinary and integrated approach that includes the active participation of the individual, custody staff, family and treatment providers.”
- Only in this way, can this “core function” of correctional mental health ever be actualized.
 - See Dlugacz & Roskes, *supra*, at 423: “In our view, preparing incarcerated inmates and detainees for release requires as much integration as possible.”

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Current state of affairs

- It is estimated that, in the United States, 14.5% of male adults in prisons and jails have a mental illness, as do 31% of female adults -- a rate of two to four times that of the general population, with some studies concluding that over *half* of jail inmates have been diagnosed with mental illness or are receiving treatment for a mental health-related issue.

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Current state, 2

- Jail staff workers often have no education or training in the appropriate treatment of detainees with a mental illness, and thus may respond with aggressive measures that ultimately exacerbate symptoms of their conditions.
 - Thus, no surprise that 30% of inmates in solitary confinement are mentally ill.
- Suicide is the leading cause of death in jails and prisons, and research suggests that the high suicide rates are correlated with untreated depression.
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Current state, 3

- In 2015, a quarter of all police shooting deaths involved persons with signs of a mental illness.
- These startling statistics show that continuity of care is a pressing need for persons with mental illness who are subject to the shuttling process between hospitals and prisons that is so disruptive to actual treatment.

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Impacts of deinstitutionalization

- Lack of adequate and accessible community resources for persons with MI
- Police tactics can encourage persons with MI to be arrested for minor infractions
- Privatization of the mental health system

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Conditions of confinement

- Transinstitutionalization
- Understaffing, inmates at higher risk of being victims of violence → issues of shame and humiliation
- Negative impacts of incarceration upon reentry

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Research on why continuity of care is necessary

- Leads to improvement of clinical and functional outcomes for persons with MI
- Lower health care costs by reducing rate of psychiatric hospitalization
- Outpatient treatment associated with reduced risks of arrests

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Legal arguments

- ADA guarantees right to continuity of care and reasonable accommodations to be made in prison
 - *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581 (1999)
 - *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206 (1998)
 - However, it's unclear whether ADA applies to arrests
- CPRD

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Therapeutic jurisprudence (TJ)

- Consider my earlier discussion of therapeutic jurisprudence

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Mental health courts (MHCrts)

- And now consider my earlier discussion of mental health courts.

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International human rights law (IHR)

- I also believe that it is essential for those who are concerned with the questions that we raise in this paper to take a hard look at international human rights law.
- My conclusion will be that continuity of care is required by international human rights law.

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Convention on the Rights of Persons with Disabilities (CRPD)

- The Convention on the Rights of Persons with Disabilities (CRPD) "is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection."

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Status of CRPD

- Congress has not yet ratified the CRPD.
- However, the fact that it was signed by President Obama in 2012 means that the CRPD still has weight and influence over domestic policy.
- The signing of the Convention triggers the application of the Vienna Convention of the Law of Treaties "which requires signatories 'to refrain from acts which would defeat the Disability Convention's object and purpose.'"^{*}
 - * *In re Mark C.H.*, 906 N.Y.S.2d 419, 433 (Sur. Ct. 2010)
- Importantly, New York state courts have relied on this and have cited the CRPD with approval in cases involving guardianship matters.^{*}
 - * See also, *In re Guardianship of Dameris L.*, 956 N.Y.S.2d 848, 854 (Sur. Ct. 2012)

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CRPD, key sections

- States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
 - * -- Art. 12
- States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.
 - * -- Art. 13 (2)

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CRPD, key sections, 2

- Most importantly, for the purposes of this presentation, the CRPD provides an affirmative right to health care, finding that member States must:
 - (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
 - (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

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CRPD, key sections, 3

- (c) Provide these health services as close as possible to people's own communities, including in rural areas;
- (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

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CRPD, key sections, 4

- (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner; [and]
- (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability
 - -- Art. 25.

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CRPD, summary

- A consideration of the relevant Articles of the CRPD makes it clear that our current policies – *not* providing the sort of continuity of care that would protect the persons in question from “exploitation, violence and abuse,” and *not* guaranteeing the right to protection of the “integrity of the person” -- violate international human rights law.
- If we are to provide “authentic equality” to this population so that they can truly “enjoy freedom from institutionalization,” then we must reconceptualize these policies and provide the sort of continuity of care that I am discussing here.

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Can this really matter?

- Multiple courts in NY state have relied on the CRPD in a wide variety of cases involving litigants with mental disabilities (competency, guardianship and more).
 - See generally, Michael L. Perlin & Naomi Weinstein, *"There's Voices in the Night Trying to be Heard": The Potential Impact of the Convention on the Rights of Persons with Disabilities on Domestic Mental Disability Law*, 84 BROOK. L. REV. 873 (2019).
- And see *in re Zhuo*, 42 N.Y.S.3d 530, 532-33 [Sur. Ct. 2016]:
 - "Persons with disabilities have a right to recognition everywhere as persons before the law ... [and] enjoy legal capacity on an equal basis with others in all aspects of life."
- Cases such as *Zhuo* can be cited in support of continuity of care arguments.

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How to improve continuity of care

- Initially, diversion programs can keep persons with mental illness away from the criminal justice system and instead place them on special mental health-oriented tracks.
- Diversion can occur at various stages including prior to arrest or after arrest.
- Certainly, well-operating mental health courts are a proven means of improving diversion, leading to better outcomes for the cohort of individuals involved..

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How to improve, 2

- Providing mental health screening for every arrestee can lead to that person being diverted into mental health treatment.
 - Initial intake interview is a critical component of effective mental health treatment as it allows officials to ascertain whether the person was receiving treatment in the community, and also connects inmates with treatment, especially in those cases where they were not receiving adequate treatment in the community.
 - Mental health screening should be validated to accurately identify mental illness.
 - Mental health screening should also be routinely administered upon any transfer between prisons, upon admission within a prison to a segregation unit, and, also, on an as-needed basis, and should include assessment of suicidal risk.

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How to improve, 3

- Improving conditions in prisons and jails can also improve continuity of care for persons with mental illness.
- Proper mental health training for corrections officers can also help identify inmates should they need mental health treatment during their incarceration and ensure that the interactions between staff and inmates with mental illness are therapeutic.
- Psychiatric rehabilitation programs are needed including education and vocational training, social skills training, anger management, and substance abuse treatment.
- Intermediate care, between inpatient and outpatient treatment, is also a crucial component.

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How to improve, 4

- Discharge plans must be tailored towards individual needs and must be culturally relevant.
- Comprehensive transitional services must provide access to mental health treatment, job opportunities, family unification, and cognitive skills training.

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How to improve, 5

- Availability and quality of community mental health treatment should be improved to address continuity of care issues.
- Increasing the availability of educational and vocational training and mental health and substance use treatment, increases the chance of successful reentry and reduces recidivism.
- The first days and weeks that an inmate is released are crucial in that the inmate poses the most danger to themselves, their families and peers.
 - By investing greater resources in using this vulnerable time to achieve socially desirable outcomes, public health workers can interrupt the cycle of relapse and recidivism.

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Conclusion

- Continuity of care can be improved through interventions such as mental health courts, diversion practices, mental health screening, and, potentially, the use of psychiatric advance directives.
- Better training for corrections employees, court personnel, lawyers, judges, police officers can lead to better therapeutic outcomes.

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